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ABSTRACT

This guide was developed by the New York State Education department to assist schools in the formation, review, or redesign of school smoking policies. Basic considerations and policy rationale are discussed. A description of policy establishment involves: (1) formation of a task force, drawing members from school and community: (2) selection of task force coordinator: (3) means of collecting data upon which to base recommendations: (4) issues for task force consideration: and (5) regulations for students, staff and visitors. The policy considered involves a continuing tobacco education program, K-12. Stages of implementation include board review and approval, staff training, and review and update. A list of informational resources is followed by appendices of smoking laws, acts, cessation programs, and a listing of New York offices of heart, lung, and cancer associations. (NRB)

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Guidelines for Development of School Policies Regarding Smoking

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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TABLE OF CONTENTS

		PAGE
I.	Introduction	1
II.	Basic Considerations	3
III.	Rationale	4
IV.	Policy Establishment Methodology	5
	A. Cooperative Process	5
	B. Task Force Coordinator	6
	C. Data Collection	6
	D. Questions and Issues for Task Force Consideration	7
	E. Regulations: Students, Staff, Visitors	9
V.	Policy Content	11
VI.	Stages of Implementation	14
	A. Board Review and Approval	14
	B. Staff Training	15
	C. Review/Update	15
VII.	Informational Resources	18
VIII.	Appendixes	
	Appendix A: Education Law, Section 804 (Chapter 982, 1977)	20
	Appendix B: Information Supporting 1979 Clean Indoor Air Act	22
	Appendix C: Clean Indoor Air Act	26
	Appendix D: Blueprint for a High School Smoking Cessation Clinic	29
	Appendix E. Smoking in School: A No Win Situation? Maybe Not	32

PAGE

VIII. Appendix F: To Smoke or Not to Smoke 36

Appendix G: Laws of New York, Chapter 80, Public Health Law 39

Appendix H: Memorandum To All School Superintendents 40

Appendix I: County Unit Offices of the New York State Division, American Cancer Society 41

Appendix J: New York State Offices of the American Heart Association 45

Appendix K: New York State Offices of the American Lung Association 47

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I. INTRODUCTION

In spite of overwhelming evidence of the significant health hazards associated with the use of tobacco, and some efforts at prevention education, smoking remains a problem in our schools. Smoke-filled lavatories, inconsistently enforced rules, tension between smoking and nonsmoking staff members, public smoking restrictions, interest in provision for "smoking areas," mounting research evidence emphasizing adverse health consequences of "sidestream" and "second-hand" smoke to nonsmokers, and other recent significant issues, press for review of present policies and a general reassessment of the school's roles in education, containment, enforcement, and the modification of behavior regarding smoking.

The State Education Department, Bureau of Drug Education, offers schools these guidelines to facilitate formation, review, or redesign of school smoking policies that are appropriate to the local community, and that effectively address the issues of tobacco education and smoking behavior. The guidelines are designed to help surface key issues so that local districts can plan and develop their own policies.

The complexity of the issues surrounding smoking and tobacco education, coupled with commitment to a planning process and the desire to gain input from a wide variety of experts and interest groups, prompted the Bureau of Drug Education to form an advisory committee for information and

guidance in the development of this document. The membership of this advisory committee represented building administrators of several school districts, persons working in pupil personnel service, representatives from the New York State Parent-Teachers Association, the New York State United Teachers, the State Education Department's Bureau of Drug Education and the Commissioner's Student Affairs Task Force, health educators, representatives from the American Lung Association, the Hudson Valley Health Systems Agency, and the Regional Planning Center of the Albany-Schenectady-Schoharie BOCES. With grateful appreciation for their services, we recognize the members of the advisory committee listed on page v of these guidelines.

II. BASIC CONSIDERATIONS

While there is a need for policy to be generated locally, there are some considerations that are germane to all schools and are basic to the process of smoking policy development. A major function of the school is to teach good health practices and discourage poor health habits. The school should teach critical thinking and provide assistance in individual decision making regarding behaviors affecting health. In developing a district policy on smoking, school officials:

-- must give their primary attention to making sure their students are receiving accurate, up-to-date information about tobacco use.

-- should discourage the unsafe and unhealthful practice of smoking.

-- must protect individual rights for: a clean environment, "due process," and personal decision making.

-- should assist those who wish to break the smoking habit by offering direct assistance, or by referral to helping agents or agencies in the community.

Education Law, Section 804 (Chapter 982, 1977) requires instruction to discourage use of tobacco as part of the regular school health program in elementary, junior high and senior high school (See Appendix A.) Therefore, students, parents and the general public have a right to expect that schools will make an effort to provide their students with every opportunity to learn as early as possible about the health hazards of smoking.

To help in this endeavor, a new and unique tobacco education curriculum (K-12) jointly developed by the American Lung Association of New York State and the State Education Department's Bureau of Drug Education is available upon request.

III. RATIONALE

There is value in developing a comprehensive policy related to tobacco use that defines educational goals and practices for students, staff, and visitors at all programs and events, taking place on school property.

Local fire ordinances and local and State laws may establish parameters for local policy development. The local fire marshall should be consulted concerning any designation of areas where smoking may be permitted. The Clean Indoor Air Act (see Appendix B & C) which has been and continues to be considered by the New York State Legislature, and any other proposed bills that are written to control smoking behavior in schools and other public places, should be noted.

Vital to the success of the policy is the process through which it is developed. There is a need for each district to define its position toward smoking education, containment, prevention, enforcement, and behavior modification to insure that it is pubicly affirmed by the various groups who will support and/or implement the policy. Any policy statement can be expected to challenge some groups and constrain others in the same school. Effective policy implementation, then, requires identification and utilization of interests, strengths and resources of each group. Each group must feel respected and consulted through developmental stages, and feel ownership in the resulting policy. The method of policy development can greatly enhance public understanding, acceptance, and support from the total school/community.

IV. POLICY ESTABLISHMENT METHODOLOGY

Boards of education, by their statements of policy, set the tone for the whole tobacco prevention program. A concerned expression of their desire to assist students in making responsible decisions regarding smoking is important. Genuine concern and dedication to a comprehensive and effective approach can be demonstrated by the process of policy development.

A. COOPERATIVE PROCESS

A cooperative process of policy development is appropriate for dealing with the complicated issues surrounding behavior choices through prevention education and regulation of smoking behavior. The cooperative process can be initiated by the board by forming a representative task force charged with examining the issues and resources and developing recommendations for district policy for the approval of the Board of Education.

The membership of the task force (policy recommending body) should be broadly representative of all elements of the school/community:

-- school board

-- teachers

-- teacher organization

-- students

-- curriculum specialist

-- district coordinator of health education

-- school administration

-- health educators

-- school nurse-teachers

-- Parent-Teacher Association

-- American Lung Association

-- American Cancer Society

-- American Heart Association

-- local health professionals

B. TASK FORCE COORDINATOR

When the membership of the policy recommending group is determined, a staff member should be chosen to coordinate the efforts of the group. It is important for that person to have experience in use of effective group management skills. Particularly the individual must possess skills for designing and implementing a strategy to insure that:

-- Common goals are determined by the group;

-- Group members work with peer status;

-- Opportunities are provided for group interactions;

-- The total resources of each group member are utilized;

-- Leadership is shared and opportunities are provided for leadership to emerge;

-- Plans are developed to realize the goal(s) of the group;

-- Individual needs as well as group needs are recognized;

-- Opportunities for communication are maximized;

-- The task is accomplished and the group members feel ownership for their recommendations.

C. DATA COLLECTION

After formation of the policy recommending body or task force, and after the goal(s) of the group are mutually under-

stood and accepted, a vital task is to collect the necessary data upon which the group may base its recommendations. This data can come from:

1. The sharing of backgrounds, professional experiences, and special interests of the members of the task force;
2. Interviews of key people in the community such as the local fire marshall, the school attorney, district superintendent of schools, school physician, etc., who may not be members of the task force but who can clarify basic points of information;
3. Questionnaires which facilitate awareness of the existing goals and activities of the task force, provide a large and useful data base, and give opportunity for large numbers of people to feel heard and to be involved in the process of dealing with this important health issue;
4. Open forum meetings during which interested members of the school and community may make input and become part of the process;
5. Use of printed resources which are available to provide background knowledge, and information on methods other communities have utilized.

D. QUESTIONS AND ISSUES FOR TASK FORCE CONSIDERATION

The basic considerations stated earlier in this document serve as a useful springboard for discussion. For the purpose of convenience they have been placed in the form of questions and

included here for task force consideration.

1. What are the appropriate purposes of a smoking policy for your district?
2. What needs will be served and for whom? Examples:
   -- The needs of those who have not begun to smoke to receive education for reinforcement of nonsmoking behavior;
   -- The need to respond to those who are already smoking but wish to stop;
   -- The needs of those who must have (or) prefer a smoke-free environment -- including but not limited to people who have emphysema, asthma, bronchitis, sinusitis, hay fever, chronic heart disease;
   -- The needs of those who decide to smoke and desire an appropriate place to do so.
3. What is the proper role of the school in relation to tobacco education, containment/prohibition, enforcement, punishment, and modification of behavior through provision of smoking clinics or cessation programs, etc.?
4. How can the school encourage responsible decision-making for personal health?
5. What should the scope of the policy be in terms of restrictions and facilities for students, staff, visitors; evening programs, meetings, sports events, etc.?
6. Should the regulation of smoking behavior differ based on age or position in the school?

7. How can we deal with the individual's right to decide to smoke in an appropriate place vs, the factors of peer and adult modeling and the environmental impact of smoke?
8. How can we respect individual rights while enforcing policy regulations?
9. How practical are each of the separate elements of the policy in terms of general acceptance, implementation, enforceability, cost, and commitment?
10. How will we make the public aware of the policy?
11. How can public support be generated for the policy?
12. How will the policy be implemented?

E. REGULATIONS: STUDENTS, STAFF, VISITORS

It is important for the policy to include people who work in or visit the schools in the district. The issue of smoking in school should be settled for teachers, other staff members, students and parents. Any areas where smoking is permitted should be clearly specified and properly equipped. These areas should be defined in terms of who may use them and how one gains access to them; i.e., by being a member of the staff, by written parent permission, by participation in a smoking cessation program, etc. The regulations should be consistent with local fire ordinances, supervisory regulations, local and State laws and staff contracts.

Disciplinary measures should be clearly outlined, consistent with supervisory regulations, and responsive to individuals' rights. Disciplinary measures should be clearly explained as

responses to violation of rules rather than violation of one's health. The policy-forming group may wish to consider a combination of disciplinary measures of policy enforcement with constructive alternative programs. A combination of discipline and educational practices may be better than either one or the other. Regulations regarding adult smoking behavior need to be workable, understandable, enforceable and responsive to needs of all groups.

Effectiveness of the policy depends on the degree to which the school community understands and supports it, how the community follows and assists in the enforcement of the policy regulations. Students in particular need to be aware that the quality of the school environment, as well as attitudes of adults toward students in general, is affected adversely by those who violate the policy regulations. Students have much to gain by doing their part to influence peers to cooperate with policy regulations.

V. POLICY CONTENT

The school district policy on smoking offers an appropriate opportunity to affirm a commitment to education for the prevention of tobacco use. The State Education Department and several voluntary agencies have excellent curriculum materials on smoking and health for grades K-12. These are available to your school and can be used to provide an effective base for local program development/up-date.

Effectiveness of prevention is partly dependent on carefully planned and coordinated curricula that extend throughout the total school program, K-adult education. Tobacco education should be taught in the context of the K-12 health education program and reinforced in related subject areas such as science, language arts, social studies, human ecology, etc. Critical to success is the need for well qualified and carefully trained professional educators. Recent knowledge of the psychology, sociology, physiology, public health, consumer health, economics, and politics surrounding the tobacco industry, individual tobacco use, and recent advances and techniques for prevention education must be part of the teacher's arsenal of knowledge and skills. The administration and school board should assess possible local needs for inservice education to assist teachers to:

1. increase self-awareness and sensitivity to the feelings of others;

2. discriminate between fact and fiction regarding tobacco;

3. recognize personality factors related to smoking and other forms of substance abuse;

4. increase communication skills necessary for meaningful dialogue with students;

5. respond to students' questions about tobacco with certainty and assurance;

6. develop effective classroom learning experiences for tobacco education;

7. objectively critique audiovisual and printed materials for classroom use;

8. develop techniques for encouraging personal decision making;

9. clarify their own attitudes and values with regard to smoking and smokers.

Recent research on smoking behavior of adolescents shows that the decision to become a smoker is greatly influenced by behavior of significant others in the life of the youth. The lowest frequency of smoking was found among teenagers who live in households where both parents do not smoke, and who have older brothers and sisters who do not smoke. Therefore, it is important to involve parents in tobacco education because they serve as role models. Informational programs and cessation programs should be offered to parents through various types of evening adult education programs. The Parent-Teacher Association can be helpful in involving parents in smoking education and antismoking campaigns. Local voluntary health agencies and hospitals may be able to help by providing informational sessions, coordinating community action programs, running cessation clinics, etc. They may also be able to provide resource

personnel and materials to enrich the instructional programs. Cessation clinics should be offered to students during school hours. These same resources are available for such purposes.

In spite of the school's best efforts to accomplish preventive education, some students will continue to decide to smoke. The coordinated efforts of the school are only one of the influential aspects of the environment of young people. Beyond preventive education there is a need to respond to youths and adults who desire to stop smoking and need help in doing so. Some possibilities for meeting this need include:

-- Developing an optional unit on smoking cessation as part of the health curriculum, managed by a specially trained health educator;

-- Inviting trained professionals from local health agencies to run informational programs and cessation clinics in the school. (These could be open to staff and parents as well as students.)

-- Referring students and adults to helping agencies in the community for help;

-- Disseminating consumer information on a variety of services to smokers who wish to break the habit;

-- Developing an elective course for credit for smokers, in which the main objective is termination of smoking behavior.

Your district may consider peer teaching programs. These programs have had demonstrated effectiveness in schools. Older volunteer students who have a thorough knowledge and experience with tobacco provide programs to younger students in school health classes. Students who have proved themselves influential in various areas of school life and are respected and admired by their peers, are very effective in this type of program. These older students are trained by teachers and community resource persons prior to classroom entry.

VI. STAGES OF IMPLEMENTATION

A. BOARD REVIEW AND APPROVAL

The policy-recommending group has the responsibility to develop its recommendations through a process that guarantees involvement of all elements of the school community. Its membership, data collecting efforts, and open public deliberations should facilitate such involvement. The group should use its own membership to inform all represented groups of outcomes of the committee's work. Dissemination and discussion of recommendations should be widespread, and mechanisms for feedback and refinement implemented, before final recommendations are presented to the Superintendent and the Board of Education. It is particularly important for the teaching staff to have regular input into the process and ample opportunity to lend support to the final recommendations. School Board hearings can be scheduled so residents of the district can speak to the Board regarding the policy recommendations before it. This final chance is needed for open dialogue so that the community can be attuned to the position of the task force and Board.

After gaining community feedback on the policy recommendations, deliberation within the Board of Education is complete, and a policy is adopted, another informational effort is needed. The policy and any accompanying administrative regulations must be clearly understood by all elements of the school com-

munity. Knowledge of the policy and the thinking behind it promotes smoother implementation and acceptance of it.

B. STAFF TRAINING

An administrative plan will be needed to facilitate the phasing in of the approved policy. An early step to successful implementation is to insure complete awareness and understanding of the policy and its behavioral implications for staff, students, and visitors.

For the educational component of the smoking prevention program to be effectively implemented, there is a need for teachers to be provided with the necessary knowledge and skills, and equipped with effective instructional lessons and materials. All this can be accomplished by the efficient use of utilizing present resources through a well planned and implemented inservice education program. Assistance in the design and execution of such a program can be obtained from a number of agencies and persons such as: the district coordinator of health education, school nurse-teachers, State Education Department Bureau of Drug Education, Regional Health Education personnel and curriculum specialists, American Lung Association, American Heart Association, American Cancer Society, local hospitals, etc.

C. REVIEW/UPDATE

A most important part of the administrative plan for implementing the policy should be the inclusion of measures for gaining data on the effectiveness of the policy; how well the policy facilitates the

realization of the goals established, practicality in terms of acceptance, enforcement, cost and commitment. The Board of Education should call for a periodic review of the stages of implementation of the policy and its related programs. Schools should be prepared to modify their policy based on data gathered from practical in-house experiences.

It is the hope of the advisory group preparing this document that schools will take seriously their role in smoking prevention and will set an example for their community to follow by considering smoking as a major health problem.

The following section contains information on smoking surveys and policies, laws and regulations, current literature, curriculum development, peer approach to smoking education and smoking cessation programs.

We hope this information will assist you as you develop your own "School Policies" regarding smoking and tobacco education.

VII. INFORMATIONAL RESOURCES

For information regarding "Educational Policies Service" to the schools (request brochure describing services and membership fees) write to:

National School Boards Association
1055 Thomas Jefferson Street, N.W.
Washington, D.C. 20007

For a survey of the current literature make requests to:

Educational Programs and Studies
Information Service (EPSIS)
New York State Education Department
Room 330 EB
Albany, New York 12234

(They can search current literature and provide listings, provide microfiche copies of materials, and journal article citations.)

For curriculum materials, information and(or) curriculum development/program planning assistance contact:

State Education Department
Bureau of Drug Education
Room 960 EBA
Albany, New York 12234

Local Chapter: American Lung Association

Local Chapter: American Heart Association

Local Chapter: American Cancer Society

For information regarding the new 1979 Surgeon General's Report on Smoking and Health contact:

Office on Smoking and Health
Park Building, Room 158
Rockville, Maryland 20857

APPENDIX

EDUCATION LAW
(CHAPTER 982, 1977)

§§ 804. Health education regarding alcohol, drugs and tobacco abuse

1. All schools shall include, as an integral part of health education, instruction so as to discourage the misuse and abuse of alcohol, tobacco, and other drugs and promote attitudes and behavior that enhance health, well-being and human dignity.

2. Instruction regarding alcohol, tobacco, and other drugs shall be included in the health education provided for all elementary school pupils and shall be taught by the regular classroom teachers or by teachers certified to teach health education. Such instruction shall be designated according to the needs and abilities of the pupils at successive grade levels with the purpose of developing desirable health behavior, attitudes, and knowledge as well as self-reliance and problem solving capacity.

3. Instruction regarding alcohol, tobacco, and other drugs, in addition to continued health guidance in the junior high school grades and the senior high schools, shall be an integral part of a required health education course at each of these levels in the secondary schools curriculum. Any such course shall be taught by teachers holding a certificate to teach health. Related courses in the secondary school curriculum shall be taught in a manner supportive of health education regarding alcohol, tobacco, and other drugs.

4. The commissioner may prescribe in regulations such health education courses which include instruction regarding alcohol, tobacco, and other drugs as he may deem necessary and desirable for the welfare of pupils and the community. The contents may be varied to meet the needs of particular school districts, or portions thereof, and need not be uniform throughout the State.

5. School authorities shall provide the needed facilities, time, and place for the instruction set forth herein and shall provide learning aids and curriculum resource materials which contribute to effective teaching methods and learning in health education regarding alcohol, tobacco, and other drugs.

6. All pre-service training programs in the State for elementary teachers shall include adequate preparation regarding the instruction in alcohol, tobacco and other drugs set forth herein, and no teacher shall be licensed except upon satisfactory demonstration of the competencies included in the institutional proposals approved by the education department.

7. Nothing contained in this section shall be deemed to diminish or impair the duties of the commissioner with respect to the continuing program for critical health problems established by chapter seven hundred eighty-seven of the laws of nineteen hundred sixty-seven as amended. The commissioner shall coordinate actions taken under authority of this section with the provisions of said chapter as they relate to health education in schools, inservice training and training programs, and curriculum or syllabus development regarding the deleterious effects resulting from the use, misuse, and abuse of alcohol, tobacco, and other drugs.

Added L.1977, c. 982, § 1.

Effective Date. Section effective July 1, 1977, pursuant to L.1977, c. 982, § 2.

Derivation. Former sections 804 and 804-a. Said former section 804 was added L.1947, c. 820, § 1; amended L.1952, c. 413, § 1, and repealed by L.1977, c. 982, § 1. Said former section 804-a was added L.1952, c. 413, § 2, and repealed by L.1977, c. 982, § 1.

§ 804-a. Repealed L.1977, c. 982, § 1, eff. July 1, 1977

Section which related to instruction regarding the nature and effects of narcotics and habit-forming drugs was added. L.1952, c. 413, § 2. The subject matter is now covered by section 804.

INFORMATION SUPPORTING 1979 CLEAN INDOOR AIR ACT

American Lung Association of New York State

Some Things You May Not Know About Smoking and Second-Hand Smoke

Today's cigarette smoker has approximately a 70% greater chance of dying from disease than the nonsmoker. A particularly high correlation exists for those who began smoking at a young age. Fifteen years after smoking cessation, the mortality ratio for former smokers approaches that of persons who never smoked. Coronary heart diseases and lung cancer are the chief killers of smokers.

A lighted cigarette generates about 4,000 compounds which can be separated into gas and particulate phases. Carbon monoxide (the gas phase) and nicotine and tar (the particulate phase) are the most likely contributors to the health hazards of smoking.

Nicotine is responsible for physiological responses, increased heart rate, blood pressure, cardiac output, stoke volume, oxygen consumption, coronary blood flow and arrhythmias.

Cigarette smokers report more acute chronic conditions than persons who never smoked. The age adjusted incidence of acute conditions for smoking males is 14% higher than for men who have never smoked and 21% higher for females who have never smoked. This data has been developed from statistics on workdays lost, sickness and limitations on activities result from chronic disease.

Smoking is one of the three independent risk factors for heart attack.

The only significant increases in the smoking population in recent years have occurred among teenage women. At the same time, the lung cancer ratio in women is increasing more rapidly than in men. If present trends continue, this disease will be the leading cause of cancer death in women in the next decade.

Evidence is accumulating about the relationship between tobacco use and cancer of the larynx, oral cavity, esophagus, urinary bladder, kidney and pancreas, and pipe and cigar smokers experience practically the same risk as cigarette smokers for all of these concerns except lung cancer.

Both weight and fetal growth are significantly affected by cigarette smoking during pregnancy. Babies born to women who smoke are lighter in weight, and in children of parents who smoke, bronchitis and pneumonia are more common during the first year of life than in children of nonsmokers.

Twenty-nine million Americans have quit smoking since 1975. Presently, 32.2% of the adult population smokes, down from 41% in 1966.

The total direct health care cost of smoking, including smoking-related illnesses and property damage due to fires caused by careless smoking (adjusted to 1976 prices) is $8.2 billion, or approximately 7.8% of the total health care cost in the nation.

The total direct and indirect economic cost of smoking-induced illness is $27.5 billion, or 11.3% of the comparable aggregate cost of all illnesses. This high percentage is probably due to the high health care cost of cancer, cardio-vascular and respiratory diseases. Lost earnings due to cigarette smoke are nearly as high (95%) as lost earnings due to alcoholism.

A Word About Second-Hand Smoke . . .

Tobacco smoke can be a significant source of atmospheric pollution in enclosed areas. Occasionally under conditions of heavy smoking and poor ventilation, the maximum limit of an 8-hour work exposure to carbon monoxide (50 ppm) may be exceeded. The upper limit for carbon monoxide in ambient air (9 ppm) may be exceeded even in cases where ventilation is adequate. For an individual located close to the cigarette that is being smoked by someone else, pollution exposure may be greater than would be expected from atmospheric measurements.

Cigarette smokers inhale and exhale mainstream smoke eight or nine times with each cigarette for a total of 24 seconds. But the cigarette burns for 12 minutes and pollutes the air continuously with sidestream smoke, which is more noxious than mainstream smoke (two times the tar and nicotine and five times the ammonia).

Cigarette smoking in enclosed spaces produces carbon monoxide levels well above the Ambient Air Quality Standard, even where ventilation is adequate. Carbon monoxide at levels occasionally found in cigarette smoke-filled environments have been shown to produce slight deterioration in some tests of psychomotor performance. It is unclear whether these levels impair such complex psychomotor activities as driving a car. The effects produced by carbon monoxide may become important when added to factors such as fatigue and alcohol, which are known to have an effect on the ability to operate a motor vehicle.

Substantial portions of healthy adults experience irritations of eyes and nose when exposed to cigarette smoke.

Many other substances, including nicotine, carbon monoxide and ammonia, are found in much higher concentrations in sidestream smoke than in mainstream smoke. The total smoke exposure of nonsmokers is quantitatively much smaller than the exposure of smokers. But the smoke nonsmokers inhale may be qualitatively richer in certain hazardous compounds than mainstream smoke.

The effect of involuntary smoking on the individual is determined not only by the qualitative and quantitative aspects of the smoke-filled environment, but also by the characteristics of the individual. Reactions may vary with age as well as with sensitivity of the individual to the components of tobacco smoke. The possible effects range from minor eye and throat irritations experienced by most people in smoke-filled rooms to anginal attacks in some persons with coronary artery disease.

Several researchers have investigated the effects of parental smoking on the health of children. In one survey, a statistically significant relationship between the prevelance of children's respiratory infec-

tion and parental smoking was found in children from birth to age 5 and age 10 to 16. However, an even stronger relationship was found between parental cough and phlegm production and respiratory infection in children. A relationship between parental cigarette smoking and respiratory infection in their children would occur because cigarette smoking causes the parents to cough and produce phlegm and would not be indicative of a direct effect of cigarette smoke-filled air on the children.

Today's researchers are more and more concerned about the effects of second-hand or sidestream smoke The 1979 Surgeon General's Report considers some of these problems serious enough to require further study:

1. Perspective studies are needed to find the relationship between smoking and the prevelance of respiratory diseases and symptoms of pulmonary function status in children. Care should be taken to consider such compounding factors as socioeconomic status and the smoking habits of the children.

2. Further in-depth studies are needed on patients with demonstrable coronary artery disease to assess the effects of carefully defined carbon monoxide and involuntary smoking exposure on angina and other indicators of mild cardio performance.

3. Clinical (symptomatic) and physiological responses to involuntary smoking exposure should be investigated in patients with demonstrably hyperactive airways (asthmatics) and chronic lung diseases.

THE PUBLIC SPEAKS

PUBLIC ATTITUDES TOWARDS LIMITING CIGARETTE SMOKING - NEW YORK STATE

"Do you favor or oppose a proposed state law which forbids smoking in all public places unless designated as a smoking area?"

	FAVOR	OPPOSE	NOT SURE
Total	62%	36%	2%
Upstate	58%	40%	2%
Northern Suburbs	63%	34%	3%
Western New York	58%	41%	1%
New York City	65%	34%	1%

Source: Gannett News Poll conducted December, 1978

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SMOKING IN PUBLIC PLACES?--NATIONAL ATTITUDES

Some 1,507 survey respondents were handed a card and asked the following question: "In your opinion, which of the policies on this card should be followed with regard to smoking in such public places as trains, buses, airplanes, restaurants and offices?" The policies included: no restrictions on smoking; special areas for smokers; and a

total prohibition of smoking. Here are the findings:

	No Restrictions	Special Areas for Smokers	No Smoking Allowed	No Opinion	Total
NATIONAL	10%	68%	16%	6%	100%
Smokers	16%	70%	8%	6%	100%
Nonsmokers	6%	67%	22%	5%	100%

Source: Gallup Survey, August, 1977

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CURRENT NEW YORK STATE CLEAN INDOOR AIR ACT SUPPORTERS

- American Lung Associaton of New York State, Inc.
- Employee Health Service of Memorial Sloan-Kettering Cancer Center
- Medical Society of the State of New York
- American Health Foundation
- Health Systems Agency of New York City
- Blue Cross and Blue Shield Plans
- New York State Department of Health
- Employee Health Service of New York State Department of Civil Service
- New York State Congress of Parents and Teachers, Inc.
- New York State Association of Counties
- Broome County Health Department
- Greater New York Council Against Public Smoking
- The University of the State of New York, State Education Department
- New York Public Interest Research Group

STATE OF NEW YORK

S. 1968—C

A. 2746—C

Cal. No. 270

1979-1980 Regular Sessions

SENATE–ASSEMBLY

February 6, 1979

IN SENATE—Introduced by Sens. JOHNSON, ACKERMAN, BERMAN, BRUNO, DUNNE, FARLEY, GALIBER, HALPERIN, LACK, LEICHTER, MENDEZ, NOLAN, OWENS, PADAVAN, RUIZ, TRUNZO, WEINSTEIN—read twice and ordered printed, and when printed to be committed to the Committee on Health—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

IN ASSEMBLY—Introduced by M. of A. GRANNIS, HEVESI—Multi-Sponsored by—M. of A. ABRAMSON, BARBARO, BIANCHI, COOPERMAN, D'AMATO, D'ANDREA, DelTORO, ENGEL, EVE, FINNERAN, GOTTFRIED, GRIFFITH, HARENBERG, HINCHEY, HIRSCH, HOCHBRUECKNER, HOWARD, JACOBS, KENNEDY, KIDDER, KISOR, KOPPELL, LAFAYETTE, LEHNER, MARCHISELLI, MONTANO, NADLER, NEWBURGER, PAROLA, PASSANNANTE, PESCE, PILLITTERE, PROUD, RETTALIATA, ROBLES, SANDERS, SEMINERIO, SERRANO, SIEGEL, STAVISKY, STRELZIN, E. C. SULLIVAN, F. M. SULLIVAN, P. M. SULLIVAN, TALLON, VANN, S. P. WALSH, WERTZ, YEVOLI—read once and referred to the Committee on Health—reported and referred to the Committee on Codes—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee—reported from said committee with amendments, ordered reprinted as amended and placed on the order of second reading—advanced to a third reading, amended and ordered reprinted, retaining its place on the order of third reading

AN ACT to amend the public health law, in relation to protecting the public health, comfort and environment by prohibiting smoking in public places and at public meetings except in designated smoking areas and to repeal article thirteen-F of such law relating thereto

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Legislative findings and purpose. The legislature hereby finds that tobacco smoke is one of the major health hazards present in our environment.

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

8A (LBD)8A (LBD)

LBD9-51-821XC

There is substantial scientific evidence that tobacco smoke causes cancer, heart disease and various lung disorders. The legislature further finds that the harmful effects of tobacco smoke are not confined to smokers, but also cause severe discomfort and in some cases grave illnesses to non-smokers, who constitute a growing majority of the adult population. It is therefore the purpose of this legislation to protect and preserve in a reasonable manner the health and comfort of the people of this state by creating in places that are visited by the general public areas that are free from the toxic and nuisance effects of tobacco smoke.

§ 2. Article thirteen-F of the public health law is **repealed.**

§ 3. Such law is amended by adding a new article thirteen-F to read as follows:

ARTICLE 13-F

CLEAN INDOOR AIR

Section 1399-o. Definitions.
1399-p. Prohibition.
1399-q. Designation of smoking areas.
1399-r. Smoking in elevators prohibited.
1399-s. Responsibilities of proprietors.
1399-t. Local regulations.
1399-u. Violation.

§ 1399-o. Definitions. For the purposes of this article, the following terms shall have the following meanings:

1. "Bar" means a place at which the principal business is the sale of alcoholic beverages for on-premises consumption, or that area of the restaurant which is devoted primarily to the sale or serving of alcoholic beverages.

2. "Place of work" means any indoor area in which two or more persons are employed for wages or salaries or render volunteer services, excluding factories and exceptions as defined in subdivision nine of section two of the labor law and private enclosed offices occupied exclusively by smokers even though such offices may be visited by non-smokers.

3. "Restaurant" means a place in which the principal business is the sale of food for on-premises consumption.

4. "Smoking" includes the burning of a lighted cigar, cigarette, pipe or any other matter or substance, which contains tobacco.

5. "Smoking areas" means a designated area in which smoking is permitted.

6. "Indoor areas open to the public" shall include but not be limited to restaurants, retail stores, public means of mass transportation, all schools, colleges and universities, hospitals as defined by article twenty-eight of the public health law, auditoriums, theaters, libraries, museums, arenas and meeting rooms.

§ 1399-p. Prohibition. No person shall smoke in any place of work or any indoor area open to the public except in designated smoking areas. This prohibition shall not apply when an entire room or hall is used for a private social function and arrangements are under the control of the sponsor of the function and not the proprietor or manager of the room or hall.

§ 1399-q. Designation of smoking areas. 1. Smoking areas may be designated by proprietor or other persons in charge except in areas where smoking is prohibited by the fire marshall or other law, ordinance or regulation. Where smoking areas are designated a sign shall indicate their location and existing physical barriers and ventilation systems shall be used to minimize the effect of smoke in adjacent non-smoking areas.

2. The following areas may be designated as smoking areas in their entirety:

a. a bar;

b. a place of work or any indoor area open to the public with less than one thousand square feet of floor area;

c. a restaurant which seats one hundred or less persons; provided, however, that if there is more than one dining area in such restaurants it is the intent of this law to encourage the proprietor to preserve one of such areas as a non-smoking area. In the case of any restaurant or bar designated as a smoking area in its entirety, the proprietor or person in charge must post a sign so stating this designation. This sign must be posted clearly so as to be visable to the public before or as they are entering the premises;

d. a restroom; and

e. an area commonly referred to as a lobby.

§ 1399-r. Smoking in elevators prohibited. Notwithstanding any inconsistent provision of this article or any other law, ordinance or regulation, no person shall smoke in any elevator accessible to the public.

§ 1399-s. Responsiblities of proprietors. If a smoking area is designated, the proprietor or other person in charge shall post signs pursuant to this article.

§ 1399-t. Local regulations. Nothing contained in this article shall be deemed to limit the authority of a city, town or village from adopting or amending local laws which provide stricter regulation of smoking in places of work and indoor areas open to the public.

§ 1399-u. Violation. Any person who violates the provisions of this article shall be guilty of a violation punishable by a fine of not more than twenty-five dollars for the first violation and not more than one hundred dollars for each successive violation.

§ 4. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law.

REPEAL NOTE.—Article thirteen-F of the public health law, proposed to be repealed by this act, makes it unlawful to smoke tobacco in any public means of transportation and in any indoor facility such as a library, museum or theater. It would be replaced by a new article thirteen-F relating to the same subject, and expanding thereupon.

AMERICAN LUNG ASSOCIATION, HUDSON VALLEY, INC.

35 Orchard Street, White Plains, New York 10603/Headquarters
124 Green Street, Kingston, New York 12401/Area Office

BLUEPRINT FOR A HIGH SCHOOL SMOKING CESSATION CLINIC

Introduction

In any smoking prevention program, young people are often given scientific and medical facts to help convince them that smoking is injurious to their health. This, we anticipate will plan an important part in their decision making.

Where health educators have been doing a good job in smoking education, young people who are convinced are now saying, "You have convinced us that smoking is detrimental to our health, now tell us how to kick the habit."

The Approach

Once we are certain that the young people we are to work with in a smoking cessation clinic have the basic facts concerning health and smoking, we then add another facet. They need to know certain facts about human motivations and behavior that result in the formation of habits.

Though all smokers have many things in common that lead to and reinforce their desire to smoke, there are individual problems that must be dealt with. Thus it is necessary to provide an opportunity for individual counselling.

The School Approach to Smoking Cessation Clinics

Basic Requirements

1. The students must come voluntarily.
2. School time must be made available - approximately one hour for each of the three sessions, one week apart.
3. The student must be willing to take an active part in discussions and in the required reading.
4. The student must be willing to sign the Smoker's Pledge.*

Session I

1. Students are given a brief questionnaire to fill out to determine their smoking habits.
2. A brief film (Emphysema) is shown to reinforce the concept that smoking is injurious to one's health.
3. Literature on the dangers of smoking is distributed to each student as required reading for future discussions.

*Included with Blueprint (page 31)

BLUEPRINT FOR A HIGH SCHOOL SMOKING CESSATION CLINIC

4. Printed tips on how to quit smoking are made available with a request that students mark off those they could live with and could follow as their first step towards kicking the habit.

5. Students are asked to announce to friends and relatives and whoever will listen that they are giving up smoking. Such a commitment is important.

6. A signed pledge card must be given to someone who really wants to see the student kick the habit. The student is required to report daily on his progress to this person.

Session II

The clinic leader starts an informal discussion going by asking students to discuss the progress they made that week or the problems they had encountered.

The students then are asked if there was anything in the literature they read that they want to talk over.

Students are asked to discuss the reaction of their parents and friends to their announcement that they are kicking the habit.

Each student is invited to tell which tips are working for them or if they have any original ideas that are helpful, to given them to the group.

Session III - Panel Discussion

Students who have kicked the habit "cold turkey" or have appreciably cut down on their smoking by the third session are asked to serve as panelists.

Students who by their own admission have not made any progress are asked to tell of their problems and efforts to the panel.

The panelists along with the leader will try to analyze the difficulty and make suggestions that might be helpful in light of their own experience.

Those who are off the cigarettes will relate their physical and mental reactions to the others and how they coped. This encourages those who have not fully taken the step and will assist in allaying their fears about not being able to endure withdrawal.

As a final step, students are asked to give a target date at which time they hope to totally abstain from smoking to the holder of their pledge card.

Students are also requested at the end to give a progress report to the teacher or nurse sponsor of the clinic.

The final request of the clinic leader is that all participants start to think as nonsmokers. They are given lapel buttons to wear that say "Thank You For Not Smoking" and a printed sign for their room at home which gives the same message. Most important, they are to crusade for nonsmoking by trying to convince all others who will listen that smoking is a bad habit, a life shortener, detrimental to physical fitness and the pursuit of happiness.

A SMOKER'S PLEDGE

I pledge this day to make an honest effort to break my smoking habit. I further pledge that each morning I will set forth the number of cigarettes I will smoke and abide by it until the target date, at which time I will stop smoking completely.

I do this in the interest of protecting my good health - a most precious asset.

_____

Signature

(FRONT)

Benefits of Kicking the Habit

I will breathe easier.
I will feel less tired.
My sense of taste and smell will improve.
It will reduce my chances for a heart attack and lung cancer.
It will contribute to a longer and healthier life.

(BACK)

Appendix E

SMOKING IN SCHOOL: A NO WIN SITUATION? MAYBE NOT

Nov. 1977

Dr. William V. Woodward
Assistant Principal
Suffern High School
Suffern, New York

Introduction

What is to be described may on first impression seem considerably hypocritical. In this day of smoking's indisputable hazards to one's health and well being, how in the world can a public school hope to achieve the ultimate educational goal of smoke proofing a younger generation by the establishment of a smoking area on school grounds?

Nonetheless, this is exactly what we did at Suffern High School in Suffern, New York, at the start of the 1975-76 school year. Now well into the second year of the "experiment," students, teachers, administrators, board members, and parents are quite well convinced that we may have hit on an appropriate answer to this nagging problem.

The Unenforceable Rule

How so? If we are to write of hypocrisy, it can be said that it has been running rampant in schools for years--indeed decades--in the form of an unenforceable rule--namely that "NO SMOKING IS TO TAKE PLACE IN THE SCHOOL OR ON SCHOOL GROUNDS AT ANY TIME." The rule has never worked; students have flaunted it because teachers and administrators have not been able to "police" ten bathrooms and extensive acreage with any effectiveness. The spasmodic success of catching one or two kids every now and then has had no impact on the problem. We read of a school that decided to go all out one year and suspend every youngster in sight who might be a smoker. 550 kids were suspended in one year-with the result that the school still had a major smoking problem.

At Suffern High School (grades 9-12), with a school population of 2000 students from a typical cross section of America, the rule had indeed been unenforceable. In addition, faculty members could smoke, and the kids knew it; lesson by example was not about to work either, speaking of hypocrisy.

What to Do?

What to do? How does one deal with this very "real world" of student smoking in school, knowing that there is an "ideal world" (or some would say a "dream world") that schools must reach for if we are to affirm our integrity as public educational institutions?

It was this very dilemma toward which we directed our efforts in attempting to "do something" about the smoking problem at Suffern High School. The Board of Education and the administration were tired and frustrated with the facts that nonsmokers could not use lavatories for their intended purpose (these rooms were "controlled" by the smokers), that teachers were forever being "hassled" by smokers they attempted to identify and "hassle," that a cat-and-mouse game was continuously being played, that we were making "sneaks" out of kids, that an entire school population was being negatively affected by the school's smoking problem.

The Board of Education appointed a committee to study the problem during the school year 1974-75 with the charge to propose a

workable smoking policy--if indeed there was such a thing. It became my dubious distinction to chair the committee. The committee's makeup was as follows: two students (a smoker and a nonsmoker), a school nurse-teacher, a junior high health teacher, and a junior high administrator. (The last two were included, for the Board wished to adopt a district-wide policy. It was recognized that the smoking problem existed in grades 7 and 8 as well).

The Committee Procedure

The committee meetings were six in number (about monthly). They were painstaking, lively, frustrating, revealing, soul searching, argumentative, and, to the last, productive. It became immediately evident that there were no easy answers. The initial step was research. Other schools were polled. Only two in our area had tried a smoking area, with limited success. The student body was polled. It was found that 30% (600 students) claimed to be smokers, and 3/4 of these smokers (450) students) said that they has smoked in school at least once. It was even more obvious that we had a large and significant problem.

Many committee members changed their minds on several occasions. Committee members were asked to seek input from other members of the school community and each committee member was asked to write a position paper to be discussed by other members.

The Policy?

What did the committee propose? The policy recommended to the Board of Education and subsequently approved by the Board is summarized as follows:

1) Indoors--No student smoking whatsoever is allowed anywhere within the school building.

2) Outside--An outside area is to be established for student smoking, centrally located, to be available for use before school, between periods, and during the lunch period.

3) Parental Permission--The outside area is to be used ONLY by students with parental permission. (Procedure-student signs up for parental permission-form mailed home and mailed back to a principal-permission card given to student.)

4) Penalties--Violators are to be suspended automatically for one day-first offense, three days-second offense, and five days-third offense. Beyond the third offense, a superintendent's conference must take place.

5) Busses--No smoking is to be allowed on busses. The penalties are: suspension from the bus for one week-first offense, three weeks-second offense, five weeks-third offense, and permanent removal from the bus for the fourth offense.

6) Corrective Action--For all smokers, mandatory attendance is to be required at corrective smoking clinics, as established by the school Health Department.

7) Faculty Smoking--Faculty smoking is to be prohibited from the faculty cafeteria, directly adjacent to the student cafeteria. In addition no faculty member is to be allowed to smoke in the presence of students before, during, or after school, or in any role as supervisor or coach of after-school activities and athletics.

8) Junior High School (grades 7 and 8)--No smoking area is to be established. Every possible preventive and corrective measure is taken (considerably smaller school makes this approach workable.

Any Success?

How has the policy worked?

The key aspects of this new policy are PARENTAL PERMISSION and CORRECTIVE ACTION. It could be said by some critics, and indeed it has on occasion, that Suffern High School condones student smoking. We do not condone the practice of smoking simply because we allow it. In actuality IF THE PARENTS OF INDIVIDUAL STUDENTS CONDONE IT, WE ALLOW IT; BUT THEN WE TRY TO DO SOMETHING ABOUT BREAKING THE HABIT. What has happened is that the smokers have been pinpointed, and the corrective action has been beamed in on them.

Other observations:

1) The school environment has been greatly enhanced. Nonsmokers are no longer haunted, bothered, or upstaged by smokers. The lavatories are completely free of smoke and smokers.

2) The climate of the school is much improved. The game of "cat and mouse" is over. Teachers no longer serve as "spies," and therefore hassles and confrontations are greatly minimized.

3) The numbers of smokers using the area has diminished from the first year in which the policy was in practice. Of course, this could change, but it seems that smoking "in the open" is not as "cool" or as challenging or as satisfying as smoking "on the sneak." Nonsmokers are not encouraged to smoke because there is an area. If anything the area demotes rather than promotes smoking.

4) The corrective action is having some impact. In addition to the clinics, teachers, administrators, and health students periodically distribute anti-smoking literature to the smokers in the area. It is a way of "meeting them where they are at." We hope for an even greater impact through a continuous effort to smoke-proof the smokers. Planned for this winter is an evening clinic for the smokers and their parents, who do the condoning and are usually extensive smokers themselves.

5) The smokers realize that their habit is not recognized as acceptable by the large majority of students as a respectably habit (part of the lesser appeal to smoke). In actuality it has become something of a chore for some to smoke, for they must go to the area rather than slip into an easily accessible bathroom.

6) The faculty has shown almost no resentment about the faculty restriction rule. Indeed there seems to be increasing numbers of teachers who are giving up smoking altogether.

7) The community seems to understand what we are trying to do. There has been no organized effort to challenge the feasibility of the smoking area. The few individuals who have questioned it seem satisfied when the parent permission necessity and the corrective action approach are explained, plus the fact that the vast majority of kids are no longer bothered by the smokers.

8) There have been a few problems with the smoking area. Supervision (checking on users who do not have permission) was lax the first year, but has been improved this year by more regular visits by administrators and teachers, equipped with "the clip board," a list of those with permission. In addition the cleanliness of the area, still a problem, is now being assisted by a team of area users who have taken on the responsibility of keeping the area clean (they don't want the area shut down). Finally the concern continues about students who may use substances other than tobacco to smoke. The increased supervision this year seems to have greatly diminished this threat, but steady vigilance is necessary, not only in the area, but everywhere.

Conclusion

In conclusion, we feel the experiment has resulted in a much more favorably approach to a very difficult and extremely important problem--that we are indeed coping now with the "real world"-i.e., what is rather than what never will be through the old unenforceable rule. We are confident that we are making a greater impact on smoke proofing our children, and that indeed we have not forfeited this major responsibility. A better school climate prevails. The two keys to community acceptance of a smoking area are parental permission and corrective action. The integrity of our role as educators in attempting to truly educate our children about the hazards of smoking is very much in tact-indeed enhanced. The real problem is being met head-on and honestly, and the ultimate goal--to smoke proof our children--is therefore that much closer to being achieved.

LAWS OF NEW YORK.—By Authority

CHAPTER 80

AN ACT to amend the public health law, in relation to prohibiting smoking tobacco in certain public areas

Became a law May 6, 1975, with the approval of the Governor. Passed by a majority vote, three-fifths being present

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The public health law is hereby amended by inserting therein a new article, to be article thirteen-E, to read as follows:

ARTICLE 13-E
REGULATION OF SMOKING TOBACCO IN CERTAIN PUBLIC AREAS

Section 1399-o. Smoking tobacco in certain public areas.
1399-p. Violation.
1399-q. Excepted areas.

§ 1399-o. Smoking tobacco in certain public areas. It shall be unlawful for any person to smoke tobacco in any form in any public means of mass transportation or in any indoor facility which is open to the public as a library or museum, or as a theater which is primarily used for, or designed for the primary purpose of, exhibiting any motion picture, stage drama, musical recital, dance, lecture or other similar performance, during such performance; provided, however, that smoking by performers as part of the theatrical production shall not be prohibited.

§ 1399-p. Violation. A person who violates the provisions of section thirteen hundred ninety-nine-o is guilty of a violation punishable by a fine of not less than ten dollars nor more than one hundred dollars.

§ 1399-q. Excepted areas. The provisions of this article shall not preclude smoking in rest rooms, or smoking in an area commonly referred to as a lobby if physically separated from the spectator area or in any other area designated as a smoking area.

§ 2. This act shall take effect on the first day of July next succeeding the date on which it shall have become a law.

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

STATE OF NEW YORK }
Department of State } *ss:*

I have compared the preceding with the original law on file in this office, and do hereby certify that the same is a correct transcript therefrom and of the whole of said original law.

MARIO M. CUOMO
Secretary of State

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

'78 JAN 19 AM 9:12

January 11, 1978

MEMORANDUM TO ALL SCHOOL SUPERINTENDENTS

Today I announced a new initiative aimed at discouraging Americans from smoking. A key element of the program involves the education of Americans to the dangers of smoking so that they can make informed choices.

No educational effort is more important than that targeted at young Americans. Those who have smoked cigarettes and quit, or who have friends that have quit or tried to quit smoking, know how extremely difficult it is to break the habit. That element of addiction makes it imperative that we educate our children and youth to the fact that cigarette smoking kills thousands upon thousands of Americans each year. We must give them the information essential to making an informed decision. The one sure way to quit smoking is not to start.

As the educational leader in your school district, you are crucial to that education effort. We urge you to play a key role in seeing that students and the people who most importantly touch their lives--parents and teachers--are fully informed about the life-threatening and crippling dangers of smoking. We will provide information and assistance, but your active and personal participation will be essential to this effort.

I hope you will work with your State education officials, the Commissioner of Education and me to develop programs which will help young Americans understand and avoid the dangers of cigarette smoking.

Sincerely,

Joseph A. Califano, Jr.

AMERICAN CANCER SOCIETY, DIVISION AND COUNTY UNIT OFFICES

DIVISION/UNIT	ADDRESS	TELEPHONE NO.	COUNTY SERVED
American Cancer New York State Division, Inc.	6725 Lyons Street P.O. Box 7 East Syracuse, NY 13057	315: 437-7025	
American Cancer Scoeity Albany County Unit	747 Madison Avenue Albany, NY 12208	518: 449-8722 (8723)	Albany
American Cancer Society Allegany County Unit	46 Martin Street Wellsville, NY 14895	716: 593-5111	Allegany
American Cancer Society Broome County Unit	216 Court Street Binghamton, NY 13905	607: 722-6471	Broome
American Cancer Society Cattaraugus County Unit	420 West State Street Olean, NY 14760	716: 372-1030	Cattaraugus
American Cancer Society Cayuga County Unit	232 West Genesee Street Auburn, NY 13021	315: 253-9812	Cayuga
American Cancer Society Chautauqua County Unit	111 West Second Street Room 260 Jamestown, NY 14701	716: 487-1129	Chautauqua
American Cancer Society Chemung County Unit	627 West Church Street Elmira, NY 14901	607: 734-1552	Chemung
American Cancer Society Chenango County Unit	5 West Main Street Norwich, NY 13815	607: 334-4113	Chenango
American Cancer Society Clinton County Unit	203 Margaret Street Plattsburgh, NY 12901	518: 563-4271	Clinton
American Cancer Society Columbia County Unit	728 Warren Street Hudson, NY 12534	518: 828-1984	Columbia
American Cancer Society Cortland County Unit	4 West Court Street Cortland, NY 13045	607: 756-2277	Cortland
American Cancer Society Delaware County Unit	Box 176 Walton Building 1 Bridge Street Walton, NY 13856	607: 865-6561	Delaware
American Cancer Society Dutchess County Unit	Hope Lodge Vassar Brothers Hospital Reads Place Poughkeepsie, NY 12061	914: 452-2635	Dutchess

DIVISION/UNIT	ADDRESS	TELEPHONE NO.	COUNTY SERVED
American Cancer Society Erie County Unit	330 Statler-Hilton Buffalo, NY 14202	716: 856-1625	Erie
American Cancer Society Essex County Unit	Water Street Elizabethtown, NY 12932	518: 873-9884	Essex
American Cancer Society Franklin County Unit	88 Main Street Saranac Lake, NY 12983	518: 891-2860	Franklin
American Cancer Society Fulton County Unit	25 Bleecker Street Gloversville, NY 12078	518: 725-3518	Fulton
American Cancer Society Genesee County Unit	103 State Street Batavia, NY 14020	716: 343-1454	Genesee
American Cancer Society Greene County Unit	375 Main Street Catskill, NY 12414	518: 943-3280	Greene
American Cancer Society Hamilton County Unit	P.O. Box 24 Hoffmeister, NY 13353	315: 826-7125	Hamilton
American Cancer Society Herkimer County Unit	125 Mary Street Herkimer, NY 13350	315: 866-3630	Herkimer
American Cancer Society Jefferson County Unit	104 Paddock Street Watertown, NY 13601	315: 788-4210	Jefferson
American Cancer Society Lewis County Unit	5611 Division Street Lowville, NY 13367	315: 376-7438	Lewis
American Cancer Society Livingston County Unit	23 Main Street Geneseo, NY 14454	716: 243-3415	Livingston
American Cancer Society Madison County Unit	East Seneca Avenue Route #5 at Willow Road Canastota, NY 13032	315: 697-2976	Madison
American Cancer Society Monroe County Unit	8 Prince Street Rochester, NY 14607	716: 461-3800	Monroe
American Cancer Society Montgomery County Unit	128 Market Street Amsterdam, NY 12010	518: 842-5580	Montgomery
American Cancer Society Niagara County Unit	2103 Main Street Bridge Station P.O. Box 314 Niagara Falls, NY 14305	716: 284-4084	Niagara
American Cancer Society Oneida County Unit	1900 Genesee Street Utica, NY 13502	315: 724-4175	Oneida

DIVISION/UNIT	ADDRESS	TELEPHONE NO.	COUNTY SERVED
American Cancer Society Onondaga County Unit	1010 James Street Syracuse, NY 13203	315: 474-2757	Onondaga
American Cancer Society Ontario County Unit	343 North Main Street P.O. Box 208 Canandaigua, NY 14424	315: 394-4422	Ontario
American Cancer Society Orange County Unit	11-15 King Street Middletown, NY 10940	914: 343-5612	Orange
American Cancer Society Orleans County Unit	111 North Main Street Albion, NY 14411	716: 589-7808	Orleans
Amreican Cancer Society Oswego County Unit	184 West First Street Oswego, NY 13126	315: 343-1421	Oswego
American Cancer Society Otsego County Unit	444 Main Street Oneonta, NY 13820	607: 432-3990	Otsego
American Cancer Society Putnam County Unit	64 Gleneida Avenue Room 209 Carmel, NY 10512	914: 225-2334	Putnam
American Cancer Society Rensselaer County Unit	24 Second Street Troy, NY 12180	518: 274-5303	Rensselaer
American Cancer Society Rockland County Unit	39 South Main New City, NY 10956	914: 634-7966	Rockland
American Cancer Society St. Lawrence County Unit	9 Hammond Drive P.O. Box 124 Canton, NY 13617	315: 386-8249	St. Lawrence
American Cancer Society Saratoga County Unit	376 Broadway - Office #2 Saratoga Springs, NY 12866	518: 584-2602 885-1613	Saratoga
American Cancer Society Schenectady County Unit	1596 Rugby Road Schenectady, NY 12308	518: 377-2241	Schenectady
American Cancer Society Schoharie County Unit	Corner, Main Street and Rail Road Avenue Middleburgh, NY 12122	518: 827-4651	Schoharie
American Caner Society Schuyler County Unit	115 West 4th Street Watkins Glen, NY 14891	607: 535-2244	Schuyler
American Cancer Society Seneca County Unit	Box 175 13 East Main Street Waterloo, NY 13265	315: 539-2052	Seneca

DIVISION/UNIT	ADDRESS	TELEPHONE NO.	COUNTY SERVED
American Cancer Society Steuben County Unit	Corner Denison Parkway East and Pearl Street Corning, NY 14830	607: 936-3769	Steuben
American Cancer Society Sullivan County Unit	10 St. John Street Monticello, NY 12701	914: 794-5275	Sullivan
American Cancer Society Tioga County Unit	231 Main Street Owego, NY 13827	607: 687-3280	Tioga
American Cancer Society Tompkins County Unit	225 South Fulton Street Ithaca, NY 14850	607: 273-0430	Tompkins
American Cancer Society Ulster County Unit	400 Broadway Kingston, NY 12401	914: 331-8300	Ulster
American Cancer Society Warren County Unit	381 A Glen Street Sherman Avenue Entrance Glens Falls, NY 12801	518: 792-5358	Warren
American Cancer Society Washington County Unit	221½ Main Street Hudson Falls, NY 12839	518: 747-7916	Washington
American Cancer Society Wayne County Unit	110 Church Street Newark, NY 14513	315: 331-6480	Wayne
American Cancer Society Wyoming County Unit	60 North Main Street Warsaw, NY 14569	716: 796-5667	Wyoming
American Cancer Society Yates County Unit	P.O. Box 113 1 Madison Avenue Penn Yan, NY 14527	315: 536-6955	Yates
American Cancer Society New York City Division, Inc.	19 West 56th Street New York, NY 10019	212: 586-8700	
American Cancer Society Brooklyn Unit	141 Livingston Street Brooklyn, NY 11201	212: 237-7850	Kings
American Cancer Society Bronx Unit	19 West 56th Street New York, NY 10019	212: 586-8700	Bronx
American Cancer Society Staten Island Unit	100 New Dorp Placa Staten Island, NY 10306	212: 987-8871	Richmond
American Cancer Society Queens Division	111-15 Queens Boulevard Forest Hills, NY 11375	212: 263-2224	Queens
American Cancer Society Westchester Division	246 North Central Avenue Hartsdale, NY 10530	914: 949-4800	Westchester

Appendix J

AMERICAN HEART ASSOCIATION, NEW YORK STATE OFFICES

CHAPTER/AFFILIATE	ADDRESS	TELEPHONE NO.	COUNTIES SERVED
American Heart Association Broome County Chapter, Inc.	8 Riverside Drive Binghamton, NY 13905	607: 723-0208	Broome
American Heart Association Central New York Chapter, Inc.	1024 Park Avenue Utica, NY 13501	315: 797-8906	Chenango Delaware Hamilton Herkimer Madison Oneida Otsego
American Heart Association Dutchess County Chapter, Inc.	31 Haight Avenue Poughkeepsie, NY 12603	914: 454-4310	Dutchess
American Heart Association Finger Lakes Chapter, Inc.	191 Parrish Street Canandaigua, NY 14424	716: 394-1240	Livingston Ontario Seneca
	Maxwell Hall Clifton Springs, NY 14432	315: 462-9062	Wayne Yates
American Heart Assocation Genesee Valley Chapter, Inc.	797 Elmwood Avenue Rochester, NY 14620	716: 461-5590 (93)	Monroe
	414 West Avenue Medina, NY 14103	716: 798-4725	Orleans
American Heart Association Mid-Hudson Chapter, Inc.	75 Lucas Avenue Kingston, NY 12401	914: 338-8517	Columbia Greene Ulster
American Heart Association Nassau, New York Chapter, Inc.	365 Willis Avenue Mineola, NY 11501	516: 741-5522	Nassau
American Heart Association Northeastern New York Chapter, Inc.	29 East Main Street Amsterdam, NY 12010	518: 843-3666	Albany Clinton Essex
	16 East Fulton Street Gloversville, NY 12078	518: 725-5111	Fulton Montgomery Rensselaer
	68 Pearl Street Hudson Falls, NY 12839	518: 747-0493	Saratoga Schenectady Schoharie
	257 Osborne Road Loudonville, NY 12211	518: 459-5880	Warren Washington
	62 Brinkerhoff Street Plattsburgh, NY 12901	518: 561-3326	

CHAPTER/AFFILIATE	ADDRESS	TELEPHONE NO.	COUNTIES SERVED
American Heart Association Northern New York Chapter, Inc.	1402 Washington Street Watertown, NY 13601	315: 782-1791	Franklin Jefferson Lewis Oswego St. Lawrence
American Heart Association Orange-Sullivan, New York Chapter, Inc.	469 Broadway Newburgh, NY 12550	914: 561-2950	Orange Sullivan
American Heart Association Rockland Division New York State Affiliate, Inc.	39 South Main Street New City, NY 10956	914: 634-4987	Rockland
New York Heart Association	205 East 42nd Street New York, NY 10017	212: 661-5335	5 boroughs of New York City
American Heart Association New York State Affiliate, Inc.	214 South Warren Street Syracuse, NY 13202	315: 478-6681	All New York State Counties excluding 5 boroughs of New York City
American Heart Association Southern Tier, New York Chapter, Inc.	530 West Church Street Elmira, NY 14905	607: 734-2939	Chemung Schuyler Steuben Tioga Tompkins
American Heart Association Southwestern New York Chapter, Inc.	812 Hotel Jamestown Building Jamestown, NY 14701	716: 483-1509	Allegany Cattaraugus Chautauqua
American Heart Association Suffolk Chapter, Inc.	127 Atlantic Avenue Blue Point, NY 11715	516: 363-6200	Suffolk
American Heart Association Upstate New York Chapter, Inc.	63 Genesee Street Auburn, NY 13021	315: 253-4328	Cayuga
	22 Tompkins Street Cortland, NY 13015	607: 753-3259	Cortland
	1212 James Street Syracuse, NY 13203	315: 476-5381	Onondaga
Westchester Heart Association, Inc.	15 Rye Ridge Plaza Port Chester, NY 10573	914: 937-6601	Putnam Westchester
American Heart Association Western New York Chapter, Inc.	255 Statler-Hilton Hotel Buffalo, NY 14202	716: 853-5356	Erie Genesee Niagara Wyoming

AMERICAN LUNG ASSOCIATION, NEW YORK STATE OFFICES

AFFILIATE NAME	ADDRESS	TELEPHONE NO.	COUNTIES SERVED
American Lung Association of Central New York	P.O. Box 6409 Syracuse, NY 13217	315: 422-6142	Cortland, Franklin, Jefferson, Lewis, Onondaga, Oswego, St. Lawrence, Tompkins
American Lung Association of the Finger Lakes Region	410 East Henrietta Road Rochester, NY 14620	716: 442-4260	Cayuga, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Yates, Chemung, Steuben, Schuyler
American Lung Association of the Hudson Valley	35 Orchard Street White Plains, NY 10603	914: 949-2150	Orange, Putnam, Rockland, Westchester, Greene, Ulster, Sullivan
American Lung Association	23 South Street Utica, NY 13501	315: 735-9225	Broome, Chenango, Delaware, Fulton, Hamilton, Herkimer, Madison, Oneida, Otsego, Tioga
American Lung Association of Nassau-Suffolk	405 Ostrander Avenue Riverhead, NY 11901	516: 727-2155	Nassau and Suffolk
American Lung Association of Western New York	766 Ellicott Street Buffalo, NY 14203	716: 886-4655	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Wyoming
American Lung Association of New York State Adirondack Branch	8 Mountain View Avenue Albany, NY 12205	518: 459-4197	Clinton, Essex, Warren, Washington,
Capital District Branch	8 Mountain View Avenue Albany, NY 12205	518: 459-4197	Albany, Rensselaer
Dutchess-Columbia Branch	246 Church Street Poughkeepsie, NY 12061	914: 452-0160	Columbia, Dutchess
Eastern Mohawk Branch	8 Mountain View Avenue Albany, NY 12205	518: 459-4197	Schenectady, Schoharie, Saratoga, Montgomery
CONSTITUENTS: American Lung Association of New York State	8 Mountain View Avenue Albany, NY 12205	518: 459-4197	

CONSTITUENTS (cont'd.)	ADDRESS	TELEPHONE NO.	COUNTIES SERVED
Brooklyn TB and Lung Association	293 Schermerhorn Street Brooklyn, NY 11217	212: 624-8531	Kings
New York Lung Association	22 East 40th Street New York, NY 10016	212: 889-3370	Bronx, New York, Richmond
Queensboro Lung Association	159-29 90th Avenue Jamaica, NY 11432	212: 526-2557	Queens